STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012688	A. BUILDING: _____ B. WING _____	09/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VANNONI LIVING CENTER, THE	500 LINCOLNWAY EAST MISHAWAKA, IN 46544

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: September 23 and 24, 2013 Facility Number: 012688 Provider Number: 012688 AIM Number: N/A Survey Team: Lora Swanson, RN TC Julie Wagoner, RN Census bed type: Residential: 8 Census payor type: Medicaid: 6 Other: 2 Total: 8 Sample: 5 Vannoni Living Center was found to be in compliance with 410 IAC 16.2 in regards to the State Licensure Survey. Quality Review 09/24/13 by Lisa McColly	R 000		